



**CAMP
MAK-A-
DREAM**

PARTICIPANT APPLICATION

Date Received: _____
(for office use only)

This application, plus a Physical Exam Form (to be completed by a medical professional) must be completed and faxed, mailed or e-mailed into Camp Mak-A-Dream before participants will be considered to attend. For participants under the age of 18, this application must be completed by a parent or legal guardian.

Participant Name: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Date of Birth: ____/____/____ Age: _____

Have you been to Camp Mak-A-Dream before? Yes No If yes, number of times: _____

How did you hear about Camp? Internet Another Participant Medical Center Other _____

Medical Center Name: _____ Contact Person: _____ Position: _____

Type of Cancer Diagnosis (Dx): _____ Date of Diagnosis: _____

Age at time of Diagnosis: _____ Date of most recent treatment: _____

CAMP SESSION (See Program Schedule at www.campdream.org for list of sessions, dates and ages)

Program/Camp Session you wish to attend: _____ Dates of session: _____

Do you have a sibling (ages 6-17) we could invite to camp? Yes No If yes, name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ E-mail address: _____

EMERGENCY CONTACT (must be parent or legal guardian for participants under age 18)

Name: _____ Daytime phone: (_____) _____

Evening (_____) _____ Cell (_____) _____ Relationship: _____

If above cannot be reached:

Name: _____ Daytime phone: (_____) _____

Evening (_____) _____ Cell (_____) _____ Relationship: _____

PHYSICIAN INFORMATION

Oncologist: _____ Primary Care Provider: _____

Institution: _____ Institution: _____

Address: _____ Address: _____

City: _____ State: _____ City: _____ State: _____

Phone (_____) _____ Phone (_____) _____

Emergency number: (_____) _____ Emergency number: (_____) _____

MEDICAL INFORMATION

Does participant have a PortaCath? Yes No If yes, type: _____
Does participant have a Central Line Yes No If yes, external or internal? _____
Does participant need help with Catheter Care? Yes No (Please bring all supplies with you)
If external line: Flushed how often? _____ Amount of Herapin? _____
Dressing changed how often? _____ May participant shower? Yes No
May participant swim in chlorine-treated pool? Yes No

MEDICATIONS

List all medications currently being taken by participant (attach additional list if needed). Participants should bring all medications (in their original pharmaceutical bottles), including Chemotherapy, catheter dressings and any other supplies needed during Camp with them.

ORAL MEDICATIONS

<i>Drug Name and Strength</i>	<i>Dose</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV MEDICATIONS

<i>Drug Name and Strength</i>	<i>Dose</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIAL NEEDS

List any allergies to foods or drugs: _____

List any other medical conditions participant is being treated for: (such as Asthma, ADD, Diabetes, Seizure disorder, etc): _____

If female, has participant begun menstruation? Yes No

If not, has she been told about menstruation? Yes No

List any special equipment (walker, crutches, wheelchair, prosthesis) used by participant: _____

List any dietary restrictions or special food needs: _____

Are participant's immunizations up to date? Yes No If no, please explain: _____

Has participant had the Chicken Pox? Yes No If yes, when? _____

Please note: Alert Camp Mak-A-Dream if participant has been exposed to any communicable disease (such as Chicken Pox, Mumps, Measles, Influenza) 1-3 weeks prior to coming to Camp.

Does participant function at age level? Yes No If no, explain: _____

Explain if unusual bedtime or sleep habits (sleep walking, nightmare, bedwetting, snoring): _____

If under age 18, does participant have permission to swim? Yes No

Does participant know how to swim? Yes No Does participant need help in water? Yes No

Please explain any other special needs: _____

INSURANCE INFORMATION (Please enclose a copy of both sides of insurance / Medicaid cards.)
To be used for special tests, treatments, X-Rays or medical consultations in the event any are needed.

Insurance coverage is under the name of: _____
Insurance Company Name: _____ Address: _____
City: _____ State: _____ Phone: (_____) _____
Policy # : _____ If Group, Name: _____ ID #: _____
If Medicaid, indicate number: _____

CONSENT AGREEMENT, AUTHORIZATION AND RELEASE

This Consent agreement, Authorization and Release must be read and signed for the participant to be eligible to attend Camp Mak-A-Dream. For participants under the age of 18, form must be completed and signed by a parent or legal guardian. Participant's full name (printed): _____

RELEASE OF LIABILITY

The undersigned understands that occasionally accidents occur during camp activities and that participants may sustain serious personal injury and property damages as a consequence thereof. Knowing the risks of camp activities, nevertheless, and in consideration of the participant's acceptance for participation at camp, the undersigned hereby agrees to assume those risks and to hold harmless the Children's Oncology Camp Foundation, and all camp agents, representatives, employees, and volunteers, from any and all liability, claims for personal injury and/or property damage, costs, expenses, and damages arising out of or connected in any way with the participant's participation in camp activities. Further, the undersigned acknowledges that Camp Mak-A-Dream accepts no responsibility for the loss, damage, or theft of personal property.

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby grants permission to the medical staff or consulting physicians at Camp Mak-A-Dream to administer medication and provide medical care, including any medical emergency care required, and any emergency transportation deemed necessary.

PHOTO AND INFORMATION RELEASE

The undersigned gives Camp Mak-A-Dream permission to photograph and use pictures or visual and audio recordings of the participant in professional and fundraising and/or marketing activities. On occasion, with this permission, participant photographs may be included in a bulletin board, video, website, newsletter, camp album, or in personal photographs. The camp respects the privacy of its participants and does not allow unauthorized visitors to photograph the camp or participants.

In addition, by signing below, the undersigned gives Camp Mak-A-Dream the permission to give the participant's contact information to groups or individuals wishing to support Camp Mak-A-Dream by sending them an invitation to an event or by sending information related to camp. This **will not** be a list sold or given to anyone else for any other reason.

PARTICIPATION CONSENT

The undersigned gives permission for the participant to participate in any and all activities, including transportation to and from camp for camp activities, except those specifically prohibited by participants' physician or parent/guardian.

X _____
Participant Signature (Parent/guardian for participants under age 18) _____ Date _____